Cherrington Dental

Savings Program

Please Circle One: Single Plan Dual Plan Family Plan

Please PRINT clearly and answer all questions or indicate "not applicable"

Applicant Profile

Name:_____. Date of Birth_____.

Please List Other People Included In The Plan

Name_____ Age_____.

Name_____ Age_____.

Name_____ Age_____.

Name_____ Age_____.

Thank you for taking advantage of our savings program. We are looking forward to providing you affordability and greater access to quality dental care. We gladly accept enrollment over the phone or you may mail this completed application with your credit card information to:

Cherrington Dental
Attn: Cherrington Dental Savings Program
2501 Fire Mesa Street Suite 100
Las Vegas, Nevada 89128

I understand that by signing this form, my savings program will be **automatically renewed each year on the same date**, using the credit card listed below.

Credit Card Information

Credit Card #_____Expiration Date_____.

_____

Applicant's Authorized Signature **Date**

Please Select Renewal Method (Check One Option)

- ☐ Single Payment For Full Amount
- ☐ Monthly Charges Beginning At Renewal Date